THREE BRANCHES MEDICAL

Suite #304 - 10 Bronte Street South
Milton, Ontario L9T 9M2
T: 289.851.2730

NEW PATIENT REGISTRATION FORM
INFORMATION SHEET

Please refer to this information sheet to assist in filling out
the Medical History section of the New Patient Registration Form.

Medical History

Please list all medical conditions and the year of diagnosis. Conditions include but are not limited to the following:

- Diabetes
- High blood pressure
- High cholesterol
- Heart disease (heart attack/heart failure/valve problems/angina
- Stroke/TIA
- Blood clot (leg/lungs)
- Peripheral vascular disease
- Anemia
- Asthma/COPD/emphysema/chronic bronchitis
- Other lung problems
- Major childhood illness
- Cancer
- Cancer treatment (surgery/radiation/chemotherapy)
- Kidney stones/kidney failure
- Urinary incontinence/prolaspsed bladder
- Gynecological conditions (endometriosis/fibroids/cysts/abnormal PAP/sexually transmitted disease
- Erectile dysfunction/enlarged prostate/sexually transmitted diseases
- Headaches/migraines
- Eye conditions (cataracts, glaucoma)
- Neurological (seizures, MS, paralysis, brain injury)
- Skin conditions: eczema,/psoriasis, skin cancers
- Upper GI: heartburn/reflux/ulcers/gallstones
- Lower GI: Crohn's/colitis/IBS
- Diverticulitis/hemorrhoids
- Arthritis: rheumatoid/osteoarthritis/gout/fibromyalgia/lupus
- Osteoporosis/osteopenia
- Hypothyroid/hyperthyroid/nodules
- Joint, muscular problems
- Depression/anxiety/bipolar, schrizophrenia
- Addictions: alcohol/drugs/gambling

Medications & Dosage

Please list all current medications including over the counter medications and herbal remedies.

Surgical History

Please list any past surgeries and the approximate year/date in which they were performed and the surgeon's name where possible. This includes childhood surgeries such as appendectomies and tonsillectomies.

Family History

Please list family member's, age & year of diagnosis. Immediate family members would be parents/siblings/children/grandparents. Conditions include the following but are not limited to:

- heart disease/heart attack/heart surgery
- stroke
- cancer – please list type
- osteoporosis/broken hip
- mental illness – please list type
- suicide
- diabetes
- blood clot in lungs or legs (DVT/PE)

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NEW PATIENT REGISTRATION FORM

Please return your completed form to Three Branches Medical at 10 Bronte Street South, Suite 304 or after hours, to Main & Bronte Pharmacy, Suite 102 on the main floor. Thank you.

Personal Information

First Name	Middle Name	Last Name
Date of Birth (YYYY/MM/DD)	Gender	Preferred Name (optional)

Health Card Number & Version Code	Expiry Date (YYYY/MM/DD)

Home Address	Contact Phone Numbers/Email
______	Mobile: ______
______	Home: ______
______	Email: ______

Occupation	Marital Status	Children

Emergency Contact	Relation To You	Phone Number

Medical & Pharmacy

Previous Family Physician	Address/City	Phone & Fax Number
Preferred Pharmacy	Address/City	Phone & Fax Number

Medical History - ***Please bring all your medications and immunization records to your first appointment.***

Medical History	Medications & Dosage
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Surgical History	Drug Allergies
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Family History (Please list family member's, age & year of diagnosis)

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Preventative Care:	Social History
Please indicate the last date (YYYY/MM/DD) of the following:	Smoking: [ ] Never smoked [ ] Previous smoker
PAP: ______________________	[ ] Current smoker ______No. cigarettes/day
Mammogram: ______________________	Alcohol history: Number of drinks/week ______________
Colonoscopy/Stool Test: ______________________	Any recreational drugs: ______________________
Tetanus Vaccine: ______________________	Caffeine Intake: Cups of coffee/day ______________
Bone Density Scan: ______________________	Exercise & physical activity: ______________________

IMPORTANT: Clinic Policies

1. All patient information is kept strictly confidential. No medical or health information will be disclosed to any third party without consent.
2. A valid OHIP must be presented before each visit to receive medical care. For all medical services not covered by OHIP, payment is required at time of service.
3. 24 hour notice is required for all appointment cancellations. A cancellation fee will be charged for all missed appointments without 24 hour notice. Thank you.

Signature: ______________________ Date: ______________________